No. 88-1503

IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

NANCY BETH CRUZAN, BY HER PARENTS AND CO-GUARDIANS, LESTER L. AND JOYCE CRUZAN,

Petitioners,

v.

DIRECTOR OF MISSOURI DEPARTMENT OF HEALTH, AND ADMINISTRATOR OF THE MISSOURI REHABILITATION CENTER AT MT. VERNON,

Respondents,

v.

THAD C. MCCANSE, GUARDIAN AD LITEM,

Respondent,

On Writ of Certiorari to the Missouri Supreme Court

BRIEF OF CENTER FOR CATHOLIC POLICY OF THE FREE CONGRESS FOUNDATION AS AMICUS CURIAE IN SUPPORT OF RESPONDENTS

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MOTION FOR LEAVE TO FILE A BRIEF AS AMICUS CURIAE ON BEHALF OF RESPONDENT

Amicus hereby respectfully moves for leave to file a brief amicus curiae in the present case. Requested consent of the parties is expected but has not yet been received and filed. When filed, it will make this motion unnecessary.

INTEREST OF AMICUS CURIAE

The Free Congress Foundation is a Washington DC Foundation doing research on items of National interest. It includes a Center for Catholic Policy which does research on matters relating to the national interest which particularly apply to Catholics.

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SUMMARY OF ARGUMENT

The assisted feeding of the unconscious battle has about the same participants on the same sides as the abortion battle. On the one side, proclaiming that we should have great respect for the sanctity of all human life, even the weakest, are most of the State legislatures insofar as they have passed legislation and the Churches which I characterize as traditional Christian, the Protestant Fundamentalists and Evangelicals and the Catholics. A high percentage of members of these Churches believe that Jesus Christ was God, that the only important thing about this life is how your soul is when you leave it, that the Bible is the inspired word of God, and that Moses received on Mt Sinai the Ten Commandments, rather than the ten suggestions. They comprise in numbers at

least about half of America. On the other side characterized as the quality of life side are the alphabet soup of prestigious organizations such as the AMA, AHA, etc, [which can demand critical about face type changes in the meaning of long used concepts such as conception in the abortion area, and nutrition, hydration and medical treatment or care in the euthanasia area, legislatures ignore these demands, but some courts use them as excuses], the media, and other change agents. They comprise nearly half of America in numbers, but far more than half of those Americans of the elite who have greater than average power.

After some initial success on the abortion question, the change agents suffered more than 100 consecutive defeats in the fifty state legislatures in their effort to force abortion change.

They then succeeded in this Court. They have had absolutely no success obtaining any of the major goals of this case in State legislatures. Nutrition and hydration are not equated with or defined as medical care in any state law. Living will laws apply only at the last moments and can not be used to terminate even medical care for anyone who would otherwise live many years. Euthanasia and intent to kill which are at the heart of this case, even though disguised as "rights" are condemned by the states. The Missouri law: [Section 459.055 (5) "Sections 459.010 to 459.055 do not condone, authorize or approve mercy killing or euthanasia nor permit any affirmative or deliberate act or omission to shorten or end life."] is typical. Unable to win what they want in the legislatures, they come to this Honorable

Court, seeking to repeat their success in the abortion cases. What logic besides numbers of voters has prevented any state legislature from passing into law any of the shopping list the change agents will obtain by reversal of this case? The legislators agree it is unethical to stop nutrition or hydration or to do anything else for the purpose of killing in large measure because of ethical arguments as set forth herein. The following arguments are from Catholic sources only because of space limitations. The Fundamentalist and Evangelical Protestants, with minor exceptions, agree. Accordingly, it is hoped that this Court will at least agree these arguments may be correct. It is hoped this honorable Court will permit the Federal system to work on this topic and derive via experience and experiments the best law on this complex subject.

On March 15, 1986, the Judicial Council of the American Medical Association issued its opinion that the removal of food and water, provided by assisted means, from medically stable and nonterminal comatose patients should not be considered unethical or illegal. The Office of Pro-Life Activities of the National Conference of Catholic Bishops has endorsed other policies.[1]

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[1] The Committee for Pro-Life Activities of the National Conference of Catholic Bishops proposed the following "Guidelines for Legislation on Life-Sustaining Treatment":

> (g) Reaffirm public policies against homicide and assisted suicide. Medical treatment legislation may clarify procedures for discontinuing treatment which only secures a precarious and burdensome prolongation of life for the terminally ill patient, but should not condone or authorize any deliberate act or omission designed to cause a patient's death.
>
> (h) Recognize the presumption that certain basic measures such as nursing care, hydra-

footnote continued:

tion, nourishment and the like must be maintained out of respect for the human dignity of every patient.

(i) Protect the interests of innocent parties who are not competent to make treatment decisions on their own behalf. Life-sustaining treatment should not be discriminatorily withheld or withdrawn from mentally incompetent or retarded patients.

"Guidelines for Legislation on Life-Sustaining Treatment," National Conference of Catholic Bishops, November 10, 1984.

And in another statement issued by the NCCB, the following was stated:

> Because human life has inherent value and dignity regardless of its condition, every patient should be provided with measures which can effectively preserve life without involving too grave a burden. Since food and water are necessities of life for all human beings, and can generally be provided without the risks and burdens of more aggressive means for sustaining life, the law should establish a strong presumption in favor of their use.
>
> For most patients, measures for providing nourishment are morally obligatory even when other treatment can be withdrawn due to its burdensomeness or ineffectiveness.
>
> Negative judgments about the "quality of life" of unconscious or otherwise disabled patients have led some in our society to propose withholding nourishment precisely in order to end these patients' lives. Society must take special care to protect against such discrimination. Laws dealing with medi-

Cardinal Joseph Bernardin and archbishop Phillip Hannan explicitly condemned the Judicial Council's opinion after it was issued.[1] For example,

footnote continued:

> cal treatment may have to take account of exceptional circumstances, when even means for providing nourishment may become too ineffective or burdensome to be obligatory. But such laws must establish clear safeguards against intentionally hastening the deaths of vulnerable patients by starvation or dehydration.

"Statement on Uniform Rights of the Terminally Ill Act," Committee for Pro-Life Activities, National Conference of Catholic Bishops, June 1986.

[1] Cardinal Bernardin wrote on April 18, 1986 in the *Chicago Catholic* that food and water were ordinary means that were to be given to the comatose and he said that the AMA Judicial Council's statement amounted to "legitimizing the denial of normal nourishment needed to sustain life." Archbishop Hannan's statement, issued on March 16, 1986, stated:

> The Catholic Church has always held that families are not obligated to use extraordinary means – such as artificial support systems – to sustain the life of a patient in a hopelessly irreversible coma. However, food and water are ordinary means of sustaining life. Therefore, the Catholic Church opposes the American Medical Association position because it approves denying a person the normal nourishment that he or she needs to sustain life.

Cardinal O'Connor called for the feeding of Nancy Ellen Jobes, Cardinal Law urged that Paul Brophy not be starved to death, and Archbishop Roger Mahony was highly critical of the court decision to allow Elizabeth Bouvia to be starved to death.[1]

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[1] On April 9, 1986, Cardinal O'Connor issued the following statement:

> Regarding the Roman Catholic position on the requirements for medical treatments to prolong life, one must look to the report of the Pontifical Academy of Sciences, released October 30, 1985, which provides, in part, that in cases of permanent coma, irreversible as far as it is possible to predict, life prolonging medical intervention need not be employed, but care, including food and water, must be provided. If any prospect of recovery is medically established, treatment is required.

In the Paul Brophy case, Cardinal Law was quoted in the Boston *Globe* on June 9, 1985 in support of the New England Sinai Hospital which was arguing for his right to be fed. The Cardinal stated: "That position is consistent with what I believe are Catholic moral and medical practices."

Archbishop Roger Mahony criticized the California Second District Court of Appeal when it allowed a feeding tube to be removed from Elizabeth Bouvia. Archbishop Mahony stated that the Court had "entered a realm where its competence does not lie." He said that "If the rea-

The Catholic bishops of New Jersey issued the most forceful statement on this matter to date by filing a brief in the Nancy Ellen Jobes case which specifically opposes the removal of food and fluids from patients because of their apparent lack of mental ability.[1]

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footnote continued:
soning of the court prevails, and a person is legally permitted to end his or her life because they perceive the quality of their life to be inadequate, are we far from the day when others – doctors, family members, judges – may actually 'order' the mercy killing of a person based on the same logic?"

[1] Brief, *amicus curiae*, New Jersey Catholic Conference, *In the Matter of Nancy Ellen Jobes*. This brief represents one Roman Catholic archdiocese, four Roman Catholic dioceses and one Byzantine Catholic diocese.

> *... nutrition and hydration, being basic to human life, are aspects of normal care, which are not excessively burdensome, that should always be provided to a patient. Nutrition and hydration are directed at sustaining life. Medical treatment is therapeutic; nutrition and hydration are not, because they will not cure any disease. For that fundamental reason we insist that nutrition and hydration must always be maintained. As the Pontifical Academy of Sciences noted in this respect in its report on "The Artificial Prolongation of Life and its Exact*

footnote continued:

Determination of the Moment of Death": "If the patient is in a permanent coma, irreversible as far as it is possible to predict, treatment is not required, but ***care, including feeding, must be provided.***

The brief also repeated a statement from the Bishops Committee for Pro-Life Activities of the National Conference of Catholic Bishops:

Because human life has inherent value and dignity regardless of its condition, every patient should be provided with measures which can effectively preserve life without involving too grave a burden. Since food and water are necessities of life for all human beings, and can generally be provided without the risks and burdens of more aggressive means for sustaining life, the law should establish a strong presumption in favor of their use.

The bishops argue that these conditions were in accord with the amendments to the federal "Child Abuse Prevention and Treatment Act," and they said that this view was endorsed by Surgeon General C. Everett Koop who said on the issue of feeding medically dependent infants that:

... the bottom line in all these cases is that you must nourish the patient (severely handicapped newborn infants). Whether an infant in a hospital is denied food and care, or whether an infant at home is denied food and care, the result is the same; it is child abuse.

The brief quoted Professor Gilbert Meilander who said the following:

... deprive a person of food and water and she will die as surely as if we had administered

FUNDAMENTAL ARGUMENTS

It is argued that medical treatments can be removed if the prolongation of

footnote continued:

a lethal drug, and it is hard to claim that we did not aim at her death.

He also said that:

For the permanently unconscious person, feeding is neither useless nor excessively burdensome. It is ordinary human care and is not given as treatment for any life-threatening disease. Since this is true, a decision not to offer such care can enact only one intention: to take the life of the unconscious person.

The New Jersey bishops challenged the argument that food and water only prolong biological life and that there is no obligation to use them. They held that a living human person exists until death occurs and that it cannot be truly called mere biological life. It is certain only that severely brain damaged persons cannot communicate with the outside world, but it is not known if they can receive communication from the outside. Neither can an interior life in these individuals be ruled out.

The bishops worried that permitting withdrawal of food and water from the comatose would put us on a slippery slope where food and water would be withdrawn from Alzheimer's patients in the near future, and they noted that some are now urging that it be withdrawn from those who are merely "pleasantly senile." They also defended the right of Parklane Nursing Home not to be forced to cooperate in a decision which was contrary to its policy.

life does not contribute to the attainment of the purpose of life … there is no need to seek to remove the fatal pathology or to circumvent its effects if the efforts would not enable the individual to achieve cognitive-affective function and strive for the purpose of life.

It is argued that to pursue this objective one must have the ability to function at the cognitive, affective and spiritual levels, and if efforts to restore functioning at this level are futile, there is no obligation to sustain physiological life. Those without cognitive-affective function (and possibly "spiritual" function) who cannot strive for the purpose of life are still persons and human beings, but one wonders what practical weight is being given to this admonition. It is claimed that it is not any specific treatment, but the life of

the person receiving the treatments, that becomes burdensome and which makes all life-sustaining treatments extraordinary. It is suggested that physiological life is not sufficiently valuable in itself to warrant any measures whatsoever to continue its existence and he wants to adopt the theory that human life has its sanctity because of capabilities for rational functioning. It is asserted that in some senses it might be spiritually better for a person to die from cancer than to accept treatment.

Critique

Advocates do not apply these criteria consistently, for in some places they speak only of a need for a cognitive and affective potential for functioning and elsewhere they speak of a need for a spiritual potentiality for functioning. If there is a spiritual capability, what-

ever that might consist in, it would seem that those with chronic depression and suicidal tendencies cannot operate toward the purpose of life.

Are the comatose so clearly different from other categories of patients that criteria can be used to permit withdrawing all treatment from them which would also justify withdrawing treatment from these other classes as well? It is very difficult to make accurate diagnoses of many patients who are neurologically unresponsive. It is claimed that those in deep coma do not experience pain, but the neurological diagnosis of "deep coma" is very ambiguous and difficult to make. Does this put many severely brain-damaged persons in danger of an excruciating death by starvation or dehydration?

Appellant's criteria in fact demand that an arbitrarily defined level of neu-

rological functioning be established before imposing any duties to give assisted food and water to the medically vulnerable. Doing this is contrary to the principles of the Older Americans Act of 1965 (U.S.C. 3801 (1982). Among other things, this act holds that older Americans are to be provided with whatever medical care and treatment is necessary to enable them to function at their highest mental and physical levels possible. It would seem that many mentally impaired patients would fit into the category of patients for whom cognitive-affective function cannot be restored and who "cannot strive for the purpose of life."

One must ask why those with diminished physical capacity to strive for human goals should be included in the category of patients from which virtually all

forms of care and treatment can permissibly be removed?

These ambiguous criteria pose a very serious threat to the handicapped and mentally ill in our state institutions, who are among the least protected members of our society. Do the severely demented, severely retarded or seriously schizophrenic people also lack the spiritual or affective potential to pursue the goals of life? Should those with advanced Alzheimer's disease, advanced senile dementia, advanced multiple sclerosis, advanced Huntington's Chorea and advanced Parkinson's dementia of Guam also be placed in this category because they have supposedly lost this capacity? Is affective or spiritual potential for human striving a clear-cut category? Their capacity to "strive for the purposes of life" is certainly limited, and one wonders why they cannot have their nutrition and fluids withdrawn. Why should not suicidal individuals who lack the affective capability to pursue human goals have a "right" to have food and water removed that is equal to that of the comatose?

Judgments about the burdens of life are complex and difficult. Having acknowledged this, they do not affirm the need to take a more protective course of action. From the viewpoint of the law, these judgments are not merely difficult, but impossible, and any attempt to make them becomes discriminatory and unjust. If the fundamental option for the "poor" means anything, it would mean that criteria for medical decision making would favor provision of care and prohibit judgments about the "burden of their lives."

Is there no duty to sustain "mere physiological life"? One must question this claim because it degrades the value of physiological life? Has it so little independent value to "mere physiological life" that there is no moral duty to sustain it when other (psychological?) capabilities have been suppressed? This view is contrary to the classical Catholic view which held that membership in the human species gives human life its sanctity.

Could treatment be withdrawn if the life of the individual receiving it was very burdensome because the withdrawal of feeding would only increase the burdens of the person's life? This lacks clarity because withdrawing feeding would only increase burdens involved in the life of the person. This view is even more rationally indefensible if one presumes

that the comatose cannot experience their environment. And if the person is able to experience his or her environment, it would seem that providing food and water would be mandatory because of the agony that is associated with their withdrawal.

Would it be better for a cancer victim to reject food and water in order to precipitate death than to continue living? This question is important because it is conceivable that such cancer patients might be closer to death than are some comatose patients. How could it be "spiritually" better to starve someone to death who cannot strive after life's goals? How can it be "better" to certainly end the life of an innocent person by denying food and water than to continue their life by providing minimal care? If such a person is incapable of "spiritual" striving, it would seem that

giving them readily providable, successful, nonpainful assisted feeding would do them no "spiritual" harm either.

Can the "end" of life be attained without potential for spiritual and cognitive and affective function? This claim demands that two questions be answered. First, in a Christian framework, should not the issue be whether the individual stands in a relation to God rather than to human goals? And second, can we thus be sure that the comatose are not striving for salvation even in their severely damaged condition? The fundamental problem with this criterion is that it leaves the critical term "purpose of life" materially undefined and does not establish an index specifying when a person actually has the power to strive for these goals. There are simply no objective criteria to determine when this

capability exists, and certainly no criteria that would be admissible in a court of law.

If physicians use this criterion so that some classes of patients can be eased out of this life, this criterion will permit other classes of patients to also be eased out by the omission of food and water. This failure creates the specter of physicians debating among themselves the nature, meaning and purpose of life before providing care and treatment. Most, if not all, physicians do not want this and are incapable of resolving in this sort of debate.

The Nature of Assisted Feeding

Is it true that withholding artificial hydration and nutrition from a patient in an irreversible coma does not introduce a new fatal pathology; rather it allows an already existing fatal

pathology to take its natural course? Do comatose patients who die after food and water are withdrawn do so because of their inability to swallow? Should decisions to provide assisted feeding be decided on the basis of the presence of a fatal pathology? When making ethical or legal decisions concerning the care of persons in an irreversible coma or with other serious pathological conditions, rather than discussing whether death is imminent or whether the patient is terminally ill, should we ask whether a fatal pathology is present? Is the important issue in determining whether assisted feeding should be given to medically stable but comatose patients not how long the patient will live with feeding, but whether there is an obligation to provide life-support systems to the seriously ill? Does life prolonging therapy aim at

removing a potentially fatal pathology – for example, surgery for cancer – or aim at circumventing or delaying the effects of the fatal pathology?

Nasogastric feeding can become burdensome to a comatose patient just as medical treatments can become burdensome to a cancer patient. There is an obligation to provide comfort and spiritual care for those patients from whom assisted feeding is withdrawn. There is an important difference between a public policy that equates nourishment with other medical treatments thereby permitting the discontinuation of nourishment and one that simply entrusts the care of the comatose or profoundly demented persons to loving, involved family members, who are to decide within the family – the terms of their decisions. To understand what is at stake, I will outline the dif-

ference between nourishment and medical treatments.

Treatments are medical interventions, designed to affect health. Treatments are outside of our customary experience. They are based on an arcane and specialized knowledge. They are given by special authorities in special settings. These authorities exercise considerable influence over the judgment to use treatment in that they are accorded special wisdom to determine whether a given therapy is medically futile, indicated, or contraindicated. Individual treatments are familiar to only a small percentage of persons. Morally, the individual is responsible for his own health, and is the principle authority as to whether treatments are used. I call this medical treatment of nourishment, "alimentation."

The ethics of feeding differs from the ethics of medical treatment. Within family transactions, we share ourselves in a collective identity, we participate in creating and maintaining shared symbolic understandings of our actions and interactions. Though from outside the family, our actions appear to express an unrestricted autonomy, from within a family we know better, we are willingly connected and bound by the integrity of the family duties and the family vision, a deep respect for the family way.

Treatments, including assisted feeding, can become burdensome insofar as the pursuing of the purpose of life is concerned. But should it not be asked if the withdrawal of food and water can also become burdensome, and if so, should not those burdens be weighed against the bur-

dens of a life that cannot pursue the goal of life?

Some state that the need for assisted feeding is a fatal condition, but if this need is a fatal condition, should not also other conditions such as a diabetics' need for insulin also be seen as a fatal condition? Should not the need for sanitary care or protection from exposure also be considered as a fatal condition as is the need for feeding?

By holding this they have established a standard which will allow many more kinds of patients than just the comatose to have life-sustaining food and water withdrawn. Many seriously handicapped, debilitated, senile and demented patients are unable to take food and fluids orally. Should we consider all of these patients as suffering from a fatal pathology as well? Definition of life-

prolonging therapies as those which prevent or inhibit life-threatening conditions is probably an accurate description of the function of medical therapies and procedures, but it fails to see that there are some procedures that must be offered by health care providers to all patients, irrespective of their clinical conditions. Implied in the view of the nature of assisted feeding is the understanding that assisted feeding is a medical treatment and is not an aspect of normal care. Assisted feeding is not a medical treatment but is an aspect of normal care because its immediate, proximate and direct finality is not to cure, remedy or palliate *clinical conditions*, but to meet the natural need of the body for extrinsic natural bodily resources. Indirectly and remotely, food and water might serve other purposes, but their

primary end is to meet the needs of the body - any body, sick or healthy - for food and water.

The aspects of basic patient maintenance have traditionally consisted of: 1) protection from exposure; 2) hygienic care or sanitary care; and, 3) provision of nutrition and fluids. These procedures merely sustain the normal bodily functions of the patient and support the natural bodily defenses of the person. These are different from medical treatments because they do not directly and immediately impede the course of already-existing pathological conditions. Traditionally, they have been provided to all patients whenever there was a need for them, which is indicted by the fact that consent is not ordinarily required to provide them. Any facility which deliberately decided to withhold these from

patients would be guilty of serious neglect and abuse.

The Vatican's "Declaration on Euthanasia" stated that euthanasia was "an act or an omission which of itself or by intention causes death, in order that suffering may in this way be eliminated." The critical issue in decisions to provide assisted feeding to the medically stable comatose is that when the provision of food and water through routine and customary nursing procedures can meet the needs of the body in a meaningful way the failure to provide them is morally equivalent to killing by omission.[1] But if the withdrawal of feeding provided by these measures will not have any impact on the clinical picture of the patient, or if the provision of assisted feeding

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[1] Sacred Congregation for the Doctrine of the Faith, "Declaration on Euthanasia." (Washington, D.C.: United States Catholic Conference, 1980).

by nursing procedures would only sustain life for a minimal period of time (a few hours or days), then its provision is not such a kind of culpable killing.

The claim that the comatose condition resulting in difficulties in swallowing causes the death of the individual after food and water have been removed is like saying that a diabetic dies from diabetes after successfully administered insulin is withdrawn from the diabetic. This is false, for if a diabetic dies after removal of insulin, it is the choice to no longer provide it that is the cause of death and not the diabetes. Similarly, when a comatose but medically stable person dies consequent to the removal of assisted feeding given through ordinary nursing care techniques, it is the effect of that choice, and not the comatose condition or the inability to

swallow that cause death. People die from coma when their neurological condition deteriorates so badly that their major organ systems fail. But when persons die after nutrition and fluids are withdrawn, they die as a result of dehydration or starvation, and coma is not the fundamental and proximate cause of death.

One must ask how it is that coma actually kills, given the fact that the symptoms associated with death from starvation appear to be identical to the kind of death attributed to coma. It is very easy to see how definitive denial of food and water kill a medically stable individual, but it is not clear how a coma kills one. When their food and water are withdrawn, these patients die from a positive decision to do nothing whatsoever to help them survive.

Coma by itself is not any more of a lethal pathology than is diabetes when minimal attention is given to it. Coma and other clinical conditions of these patients only become fatal when a decision is made to abandon all care and treatment of them, and they would not die except for such a decision. Were these patients to be provided food and water as are all other medically stable patients, their lives would not be in jeopardy. And one must ask what the proximate cause of death is of patients who have feeding tubes removed.

Some claim the degree of pain is not per se a consideration in the ethical decision concerning useless therapy; neither should it influence the legal decision concerning the burden that prolonging life may entail, but not concerning the usefulness or uselessness of life-

prolonging therapy. It is unclear why they would give consideration to pain as a factor in judging whether a feeding tube should be provided, for they reject pain as a criterion for its provision. It seems that they want to eliminate the question of the pain involved in feeding totally. They realize that invoking the issue of pain makes the case for feeding the comatose even stronger. For, if comatose patients cannot experience pain, then feeding them is no burden at least in that regard. But if they can experience pain, then denying food and water will impose severe pains on them.

The rejection of the traditional criterion of physical pain in favor of the "burden of life" standard is a frank endorsement of quality-of-life judgments. Traditional Roman Catholic medical ethics held that care or treatment became ex-

traordinary if they caused severe pain, were difficult to provide or receive, were questionable in terms of benefits or were so costly that a family could not meet its ordinary family obligations. It is claimed pain is not an operative factor in determining whether treatments should be given to patients "without a potential for cognitive-affective function and the power to strive for the purpose of life." In claiming this, they radically revise the traditional medical-ethical principles.

They argue that those who cannot strive for human goals have lives that are burdensome and it is warranted to remove all care and treatment. What if that burden is not experienced by the person, as we presume with the comatose? How can we justly remove care if there is no experience of this burden? Nobody can

demonstrate that the lives of the comatose are burdensome to themselves and that the sufferings they experience warrant withholding the minimal care necessary to provide nasogastric feeding.

Paradoxically, some deny that there is any obligation to provide food and water to a medically stable comatose person, but hold that there is an obligation to provide comfort care that is evidently and patently futile. It is senseless to give "comfort care" to individuals who are presumed to be beyond any experience of comfort or pain and who are being brought to death by denial of a crucial aspect of care. If a person is starving or dehydrating to death, giving them hygienic care and protection from exposure is certainly futile, and yet some hold that it is obligatory to give such care. It would seem that such "cosmetic care"

would be more for the benefit of the staff and family than for the patient, as it could persuade them that they are actually providing humane care for the patient. Some paradoxically demand that comfort care be given, even though they admit that the evidence that the comatose feel pain is doubtful. If they have no ability to feel pain, then comfort care would obviously be futile! If there is no duty to provide assisted feeding, why is there a duty to provide these other forms of care? One suspects that they want comfort care to be given to salve the consciences of those who decide to hurry the "biologically tenacious" along their way.

It is now argued that nutrition and fluids, no matter how they are provided, are not medical treatments and that their provision is governed by their own ethi-

cal principles. I will dispute the claim that there is no duty to provide food and fluids to incompetent patients.

In the first section, I will show how medical treatments differ from nutrition and fluids, even when they are administered by artificial means and measures that are commonly employed as therapeutic procedures. In this section, I will argue, in accord with the New Jersey appellate court and in opposition to the New Jersey Supreme Court, that nutrition and fluids are resources used by living organisms to sustain themselves. Then I will determine the principles that govern the administration of medical treatments and distinguish these from the principles governing the provision of nutrition and fluids.

A. *Medical Treatments, Nutrition and Fluids*

By their very nature, medical treatments and therapeutic procedures are artificially designed measures constructed to impede the progress of currently existing clinically diagnosable conditions, or to prevent the outbreak of future possible pathological states. Procedures such as appendectomies or coronary bypasses and medical treatments such as antibiotics impede or remedy presently existing pathological states. And such treatments as vaccines, for instance, prevent the outbreak of future possible pathological conditions. Medical treatments, *directly, proximately* and *immediately* aim at preventing clinically diagnosable conditions, and only indirectly and remotely will *some* medical treatments be of nutritional value. Treatments cor-

recting gastrointestinal disorders will have an *indirect* bearing on conditions of hunger and thirst, but they will not directly and immediately influence these states as nutrition would. Medical treatments can be fully removed from patients for their clinical benefit, so that instruments as ventilators can be fully withdrawn on occasion to improve the clinical condition of a patient.

Nutrition and fluids, even when they are provided by procedures that are commonly used to remedy or impede pathological conditions, are not directly, proximately and immediately ordered toward remedying or impeding clinical conditions, and they are not of immediate and proximate therapeutic value. Nutrition and fluids meet the basic needs of organisms to function and grow, and they are not remedies of diseases in and of them-

selves. Just as exhaustion is overcome by sleep, hunger and thirst are overcome by food and fluids. The lack of resources which sustain the natural functions of an organism is not a pathological condition, just as the lack of sleep is not a condition of disease. Nutrition and fluids are not artificially constructed impediments to clinical conditions, but are the means of fulfilling a basic human need and of supporting the body's natural defenses. Nutrition and fluids can indirectly influence the course of diseases by supporting the natural defenses of the body, but they are not directly and immediately of therapeutic value.

The fact that nutrition and fluids are on occasion provided by means that are commonly used for therapeutic purposes does not alter their nature as ba-

sic resources of the body. Just as administering poison by injection does not make it a medical treatment, providing nutrition and fluids by means used for the therapeutic does not make them medical treatments either.

Because nutrition and fluids are different from therapeutic medical treatments, the kind of medical judgment that regulates provision of food and fluids is different also. In respect to the provision of food and fluids, medical judgment is to determine what the nutritional and hydrational needs of the body are, what the best way of providing them would be and the amounts in which they are to be provided. Medical judgments regulating therapeutic procedures, on the other hand, diagnose the nature of an illness, specify the proper therapeutic procedures to be applied and formulate a prognosis

upon application of the procedures or therapies. These two kinds of medical judgment are not identical because one concerns the treatment of disease or pathology and the other concerns the meeting of basic needs of a living organism.

Given these differences between medical treatments on the one hand and nutrition on the other, it is now necessary to discuss the ethical principles that govern their administration and provision.

B. *The Ethics of the Administration of Medical Treatments*

Because medical treatments are artificially constructed procedures and measures designed to palliate, cure or remedy pathological conditions, they are governed by principles which determine the extent of burden health care profes-

sionals are to assume as a moral duty. The ethical rules governing such administration apply primarily to health care professionals and their duties to heal and remedy, and secondarily to others as they relate to the healing process.

There are two fundamental principles governing the administration of medical treatments. The first holds that ordinary medical treatments are morally obligatory under all circumstances, and the second holds that extraordinary medical treatments are morally elective and can be inculpably withheld or withdrawn. But what precisely are ordinary and extraordinary medical treatments?

Ordinary medical treatments are all medicines, remedies and therapeutic procedures which in themselves or in their clinical effects are:

1) not useless; but of clinical benefit to the patient;

2) not experimental;

3) can be provided by health care professionals without radical or undue hardship or burden;

4) can be received by the patient without undue physical pain and suffering, or undue burden, and;

5) are not the cause of radically burdensome medical and clinical effects in their administration for the patient who receives them.[1]

Examples of ordinary medical treatments would be insulin used by diabetics who are not suffering from any diseases that would imminently cause death, appendectomies for those who are not imminently dying, and surgical procedures

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[1] See: Gerard Kelly, *Medico-Moral Problems*, (St. Louis: Catholic Hospital Association, 1958) p. 129.

that repair an esophgeal atresia in a Down's Syndrome newborn infant. These treatments are not useless or experimental, they impose minimal burden on the recipients, care givers and those responsible for the care of the patient, and the effects of their administration are not radically burdensome to any of the parties involved.

If one failed to provide these treatments, or accept them if provided, then one would be culpably negligent of the goods of human life and guilty of being inadequately responsible to this fundamental good. Each and every human being has a moral duty to take reasonable measures to protect, promote and preserve his or her health and well-being. To refrain from accepting ordinary medical treatments would be an abandonment of

one's responsibilities toward the fundamental good of human life.

Extraordinary medical treatments, on the other hand, are those which either by themselves or in their clinical effects can be:

1) probably futile, or clearly useless therapeutically;

2) experimental;

3) the cause of such extreme physical pain in their administration that heroic virtue would be required to receive them;

4) the cause of such great burden or cost to health care providers that radical or heroic efforts would be required, or that they could not meet their grave moral duties by providing them;

5) the cause of such extreme deformity or pain as an effect that heroic efforts would be required by the recipient

to live with the clinical effects of the treatments, or;

6) the cause of such severe burden or economic hardship for those charged with caring for the patient that they cannot fulfill their own grave moral obligations.

An example of extraordinary treatments would be multiple amputations performed on a burn victim who is expected to die shortly. Another extraordinary medical treatment would be Dr. Barney Clark's artificial heart, not only because of its experimental nature, but also because of its final multi-million dollar price tag.

In order to determine if treatments are ordinary or extraordinary, attention must focus on what clinical effects the treatments bring about, what the capabilities of health care professionals are

and what the capabilities of those charged with caring for the patient are. Many ethicists and moral theologians reject this approach and claim that treatments should be provided according to the quality of life that is expected to result from their administration. This is an inadequate criterion, however, because it is too susceptible to biases and prejudices and because there is no rational way in which the "quality of life" of individuals could be justly and certainly assessed.

The ethical principles governing the administration of medical treatments enable moral agents to determine what is required of them to protect human life from disease and death. But these principles do not enable us to know precisely what is morally required of agents to meet basic and fundamental human needs

and sustain human life by measures that are not therapeutic or medical. To determine what these requirements are, the next section will specify the ethical principles which govern our duties to promote life and meet basic and fundamental needs in both ordinary and extraordinary circumstances.

C. *Meeting Basic Human Needs: The Ethics of Providing Life-Sustaining Nutrition and Fluids*

There are three rules which govern the provision of nutrition and fluids to incompetent patients. The first rule is that these are to be provided when they are of nutritional and hydrational benefit to the patient and when they can actually sustain life by their provision. These are always to be given for the reason that definitive removal of these universally causes debilitation and death within a certain period of time. Failing

to provide nutrition and fluids that will sustain life is never a responsible moral decision because the clinical picture of a patient is never improved by this kind of decision. Medical treatments and therapeutic procedures can often be totally withdrawn from a patient in order to improve the condition of the patient, but definitely and absolutely denying nutrition and fluids to another is actually logically and morally closer to the death of the victim than would be one who withdrew morally obligatory medical treatments. When food and fluids are denied, one sets into existence a casual chain of events that did not previously exist that is certainly and universally lethal. But when medical treatments are withdrawn one removes an impediment to an already existing or future possible lethal state

that was not actually caused by the agent.

The feelings of revulsion we commonly have about causing death by starvation or dehydration are not irrational, for they point to the extreme moral gravity of failing to provide a basic necessity of life for an individual in need. Death brought about by starvation or dehydration is particularly cruel for the reason that there are very few instances in which it is impossible to stop a person from starving or dehydrating to death. If individuals do starve or dehydrate to death in modern societies today, it is usually because others have decided that they should dehydrate or starve to death. Allowing a person to starve or dehydrate to death is particularly repugnant because the death is caused more by a failure to be responsible to ordinary

moral obligations to provide non-heroic measures to promote human life than by any other cause.

The second principle regulating the provision of nutrition and fluids holds that there is no moral obligation to provide these if it is impossible to meet the nutritional and hydrational needs of the person despite all efforts. It is not morally obligatory to provide nutrition and fluids if it is in fact impossible to feed and hydrate the person. This principle is derived from the general moral principle that there is no moral obligation where action is not possible. Thus, in the rare cases in which a patient is so badly deteriorated physically that fluids and nutrients cannot be ingested, there is no moral obligation to attempt to provide them.

The third ethical principle governing the provision of food and fluids is that they do not have to be given to patients when the mode of provision would itself cause radical and extreme pain for the recipient. This rule is based on the moral principle that heroic action can never be made a matter of moral obligation. Thus, if the means used to provide nutrition and fluids to individuals should cause extreme physical pain, it would not be necessary to provide them.

These rules imply that food and fluids should have been given to Clarence Herbert because he was only diagnosed as unconscious, and not permanently comatose when food and fluids were removed, and he was not certainly terminally ill or imminently dying. Provision of food and fluids would have been of nutritional and hydrational value to him because they

would have sustained his life. Nutrition and fluids also should have been given to Claire Conroy because they were life-sustaining for a woman who was not imminently dying, comatose or unconscious. In both of these cases, a decision to deny food and fluids would have brought death which would have resulted from a choice by physicians to refuse to meet a basic human need, and not a decision to not treat a clinically diagnosable pathological condition.

Bonnie Steinbock has argued that nutrition and fluids should have been withdrawn from Clarence Herbert because his low level of biological functioning made nutrition and fluids extraordinary.[1]

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[1] "The Removal of Mr. Herbert's Feeding Tube," *Hastings Center Report*, October, 1983, p. 15. She claims that the principle of not allowing feeding tubes to be removed from chronically unconscious patients would have grave implications. But what is so grave about this if no heroic actions are made obligatory and if they

This view fails to consider the fact that food and fluids were still life-sustaining for him and could have achieved their fundamental purpose which was to sustain his bodily functions and support its natural defenses against diseases. She claimed that nutrition and fluids should have been withdrawn on a pure "quality of life" judgment that was little more than a rationalization of her biases and prejudices. She claimed that food and fluids only supported "mere biological" life, and that food and fluids were of no benefit to him. This claim is disputable, however, in light of the fact that food and fluids would have prevented him from

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were not provided if it was impossible to meet the nutritional and hydrational needs of the patient? Far graver consequences would follow from establishing principles permitting removal of these measures from the comatose, for doing this would require that they be declared dead in spite of the fact that many of them still display many vital activities.

suffering from all of the conditions resulting from dehydration that were mentioned earlier. And it is hard to believe that the burdens involved in the provision of fluids were so great as to offset the conditions created by dehydration. The minimal or nonexistent burden involved in providing food and fluids cannot be reasonably judged to outweigh the extremely painful and grotesque death caused by dehydration.

Richard McCormick has argued that in the case of "dying incompetents" nutrition and fluids do not have to be provided as a matter of duty because they are of no benefit to them.[1] But it is

[1] *Theological Studies*, March, 1984, pp. 118-9. This view was also defended by Fr. Paris in his testimony before Judge Brian Crahan in the Herbert case. But how invasive are feeding tubes and IV lines? Dennis Horan and Edward Grant claim that there are no conceivable circumstances in which their burden could outweigh the benefits or preventing death and the substantial suffering that comes from starvation or

true that their provision would prevent these individuals from dying extremely painful deaths. Contrary to what Fr. McCormick holds, there is an ordinary moral obligation to provide food and fluids to this class of patients, as their provision is not an heroic or extraordinary measure. McCormick's view that this standard should be applied to "dying incompetent" patients is far too broad, for many of these patients would be brought to death simply by removal of food and

footnote continued:
dehydration. George Annas holds that IV's and feeding tubes should be provided according to the degree of invasiveness and according to the prognosis of the patient. See his: "Nonfeeding: Lawful Killing in Ca. Homicide in NJ." *Hastings Center Report*, December, 1983, pp. 19-20. It is speculatively possible that feeding tubes could be removed because they would require heroic efforts on the part of some patients. But the prognosis of a patient is irrelevant to the issue of providing food and fluids. For, just like sleep, nutrition and fluids are to be provided when they are needed by the patient and do not require heroic actions by the patient or providers.

fluids and not from their terminal condition. Withdrawing food and fluids from many of these patients would complicate rather than improve their condition.

In accord with the *Declaration on Euthanasia,* issued by the Sacred Congregation for the Doctrine of the Faith, I hold the nutrition and fluids are aspects of normal, routine care that is to be provided to all patients, *even the terminally ill.*[1] Medical literature has traditionally considered nutrition and fluids, even when provided by measures ordinarily used for therapeutic purposes, as an aspect of routine care rather than as specifically and precisely medical treatment. This view holds that nutrition and fluids, like sanitary care,

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[1] Sacred Congregation for the Doctrine of the Faith, *Declaration on Euthanasia,* part IV. (Washington, D.C.: United States Catholic Conference, Publications Office, June 26, 1980).

should be provided whenever they can prevent a patient from being harmed by dehydration and starvation, just as sanitary care should be provided whenever they can prevent a patient from being harmed by unsanitary conditions. Food and fluids should be given to all patients until a certain determination of death has been made because denying life-sustaining nutrition and fluids imposes harm on them.[1]

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[1] Food and fluids should be given even to the irreversibly unconscious, as they are quite alive. William Dillon, et al., point out that comatose pregnant women are quite capable of supporting their unborn children. "Life Support and Maternal Brain Death During Pregnancy," *JAMA,* Sept. 3, 1982, p. 1091. But food and fluids should also be given to those who have been diagnosed as brain dead and who display other signs of vitality, for they are only in the final stages of dying, but are not yet dead. In 1982, a woman who met all of the criteria for whole brain death was sustained by hyperalimentation and IV's for nearly a week so that her unborn child could be delivered by Cesarean Section. *Id.* In spite of a certain diagnosis of brain death, she maintained urine output, and even required insulin injections. In spite of the fact that there was no detectable brain activity, this woman was still alive because she demonstrated spontaneous integration of her major organ systems. See: Paul Batte, M.D., Sean

There is nothing immoral in providing life-sustaining nutrition and fluids to patients, and denying them these may very well violate their right to life. It is certain that absolute and definitive denial of nutrition and fluids eventually causes the greatest physical harm to individuals. Because denying life-sustaining nutrition and fluids is certainly lethal, they must always be provided when they can meet nutritional and hydrational needs and when heroic actions are not required by their provision.

The view that nutrition and fluids are aspects of ordinary, routine, normal care for all patients is becoming more widespread. Mostrecently enacted laws relating to "living

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footnote continued:
O'Reily, M.D. [Deceased], Paul Quay, S.J., Peter Salsich, Jr. "Brain Death – The Patient, The Physician, and Society" *Gonzaga Law Review*, V. 18, #3, 1982-3, pp. 429-516.

wills" require that nutrition and fluids always be provided to patients, which indicates that food and fluids are viewed as being different from medical treatments. And the Catholic Health Association recently published guidelines which held that nutrition and fluids, for handicapped newborns at least, should not be withheld.[2] And in a recent case in Massachusetts, a court reversed itself and ordered a feeding tube to be reimplanted in an elderly mental patient who had dislodged it.[3] This trend reflects a

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2 See: J. Stewart Showalter and Brian Andrew, *To Treat or Not to Treat*, (St. Louis Catholic Health Association, 1984) p. 14. The authors imply that food and fluids should always be given to handicapped newborns, even though they do not state this explicitly. But inconsistently, they refrain from holding that the comatose should be given food and fluids also, for they claim that all treatments, and food and fluids should probably be included in that category, can be removed when they are of no benefit. *Id.* pp. 25-6.

growing consensus that nutrition and fluids are the means by which basic human needs are met and are not precisely medical treatments.

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footnote continued:

3 Robert L. Barry, "Another Euthanasia Debate", *National Catholic Register*, July 15, 1984.

NO 88-1503
IN THE SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1989

NANCY BETH CRUZAN, BY HER PARENTS AND CO-GUARDIANS, LESTER L AND JOYCE CRUZAN
Petitioners,

v.

DIRECTOR OF MISSOURI DEPARTMENT OF HEALTH, AND ADMINISTRATOR OF THE MISSOURI REHABILITATION CENTER AT MT. VERNON,
Respondents,

v.

THAD C. McCANSE, GUARDIAN AD LITEM,
Respondent.

Affidavit of mailing of amicus brief copies, Rule 28.2

State of California }ss.
City of Santa Ana, County of Orange }

Robert L Sassone, being first duly sworn on his oath deposes and says:

Robert L Sassone is a member of the bar of the United States Supreme Court admitted October 26, 1971. To his knowledge, on October 11, 1989, within the particular time and permitted time for serving of said amicus brief pursuant to Rule 28.2, he deposited in the United States Mailbox at Santa Ana, CA 92701 pursuant to Rule 28.2 with first class postage prepaid 40 copies of the attached amicus brief in the present case properly addressed to the Clerk of the United States Supreme Court and three copies of said amicus brief to each party addressed as follows:

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_____
ROBERT L SASSONE, Affiant,

Subscribed and sworn to before me on
October 11, 1989,

_____
Lawrence D Sassone, Notary Public —